

FEB 18 1941

DEPARTMENT OF COMMERCE  
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH  
STANDARD CERTIFICATE OF DEATH

State File No.

1429  
389

Registration District No. 299

Primary Registration District No. 1202

Registrar's No.

## 1. PLACE OF DEATH:

(a) County Jackson  
 (b) City or town Kansas City  
 (If outside city or town limits, write "RURAL" and name of township)  
 (c) Name of hospital or institution: General Hospital #2  
 (If not in hospital or institution, write street number or location)  
 (d) Length of stay: In hospital or institution 12-16-40-1-22-41  
 (Specify whether  
 In this community 13 years  
 years, months or days)

8. (a) PRINT FULL NAME Mamie Lewis

8. (b) If veteran, No  
 name war  
 8. (c) Social Security No. NO

4. Sex Female 5. Color or race Negro  
 6. (a) Single, widowed, married, divorced Married  
 6. (b) Name of husband or wife Unknown  
 6. (c) Age of husband or wife if alive Unknown years  
 7. Birth date of deceased 26 1868  
 (Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
72 10 27 hr. min.

9. Birthplace Mo. 1)  
 (City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

## 11. Industry or business

12. Name Unknown  
 13. Birthplace Unknown 9  
 (City, town, or county) (State or foreign country)  
 14. Maiden name Unknown  
 15. Birthplace Unknown 0  
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof Apr 27-1941  
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Upton18. (a) Signature of funeral director W. H. Hatcher(b) Address 1520 W. 7th St. K.C.

19. (a) Jan 27 1941 (b) M. M. Crowe  
 (Date received local registrar) (Registrar's signature)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson  
 (c) City or town Kansas City  
 (If outside city or town limits, write "RURAL")  
 (d) Street No. 423 West 42nd St., Terraced  
 (If rural, give location)  
 (e) If foreign born, how long in U. S. A. years.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 22  
 year 41 hour 8 minute 16 P. M.

21. I hereby certify that I attended the deceased from 12-16- 1940 to 1-22- 1941  
 that I last saw her alive on 1-22- 1941  
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia  
 Due to Senility with Generalized Arterio-  
 Due to sclerosis.

Other conditions 97  
 (Include pregnancy within 3 months of death)

## Major findings:

Of operations

Of autopsy

## PHYSICIAN

Underline  
 the cause to  
 which death  
 should be  
 charged sta-  
 tistically.

## 22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
 (b) Date of occurrence \_\_\_\_\_  
 (c) Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)  
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) \_\_\_\_\_  
 (e) Means of injury \_\_\_\_\_

23. Signature R. D. Turner (M. D. or other) D  
 Address Gen. Hosp. #2 Date signed 1-23

(Licensed Embalmer's Statement on Reverse Side)

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

1 X1951

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed

*Nathan H. Matlock*

Licensed Embalmer No. *2280*

P. O. Address

*1520 N. 5th St*

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, above space should be left blank.**